County of Los Angeles
CHIEF EXECUTIVE OFFICE
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SACHI A. HAMAI
Interim Chief Executive Officer

June 22, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

REPORT BACK ON FUNDING NEEDED TO ESTABLISH A COUNTY OFFICER INVOLVED SHOOTING/DEATH IN CUSTODY REVIEW TEAM (ITEM NO. 54-C, AGENDA OF JUNE 16, 2015)

On June 16, 2015, the Board directed the Chief Executive Office to report back at the Board's budget deliberations meeting on June 22, 2015 with more informative detail regarding the Officer Involved Shooting (OIS)/Death in Custody (DIC) review team, as well as, provide the Board with a recommendation that ensures this new review team will be funded at a level which makes these cases amongst the highest priorities.

On June 12, 2015, the Department of Medical Examiner-Coroner (DMEC) distributed the attached letter to the Board, responding to statements made by a representative from Long Beach. in regards to the perceived lengthy time it takes for the DMEC to compile and release autopsy findings in OIS cases, as well as, other DIC cases (Attachment I). In the letter, the DMEC indicates that in response to these claims, meetings with the District Attorney (DA) and Sheriff Department (Sheriff) were held to explore the idea of implementing an independent review process of these shootings and in-custody deaths. Several options were considered; however, ultimately the DMEC determined that a Department-only internal review process, utilizing existing staff, should be the starting point, and no staff or additional resources were requested as part of the Final Changes.

Therefore, commencing July 1, 2015, a team consisting of DMEC physicians, criminalists, investigators, and operational staff will meet to review and analyze these cases to support risk management and quality assurance efforts. The cases will be reviewed to ensure efficiency, quality, and uniformity.

Our office will continue to work with the DMEC, DA, and Sheriff to determine the type of OIS/DIC review team that is appropriate for Los Angeles County. Options for consideration by the Board are:

- Department Internal Review Process (similar to Law Enforcement Comp Stat)
- Department Internal Review Process which includes law enforcement, DA and the Grand Jury
- DMEC Inquest

Should you or your staff have any questions, please contact Sheila Williams, Public Safety, at (213) 974-1155.

SAH:JJ:SK
SW:MI:cc

Attachment

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Medical Examiner - Coroner

ATTACHMENT I

COUNTY OF LOS ANGELES

DEPARTMENT OF MEDICAL EXAMINER-CORONER

1104 N. MISSION RD. LOS ANGELES, CALIFORNIA 90033

"Enriching Lives"

Mark A. Fajardo, M.D.
Chief Medical Examiner-Coroner

June 12, 2015

TO: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Sachi A. Hamai

FROM: Mark A. Fajardo
Chief Medical Examiner-Coroner

SUBJECT: OFFICER INVOLVED SHOOTING/DEATH IN CUSTODY REVIEW

This letter is written in response to a statement made by a Long Beach Councilwoman to Supervisor Knabe, in regards to the perceived lengthy time it takes for the Department of Medical Examiner-Coroner to compile and release autopsy findings in Officer Involved Shooting cases as well as other Death in Custody cases. My office prides itself on the ability to provide quality death investigation that is accurate, encompassing, thorough, useable and timely. We comply with the National Association of Medical Examiner's criteria that ninety per cent of our cases are completed in ninety days or less. As I reported to Supervisor Knabe, our Death in Custody/Officer Involved Shooting cases are our second highest priority cases (only second to babies) and we try to clear them as efficiently (but also as accurately) as possible. The perceived lengthy time on these (usually) very difficult cases is secondary to the necessity to analyze and collate all of the ancillary testing and reports (i.e. toxicology, neuropathology, medical records, police reports, Taser reports, etc.) to derive an accurate opinion as to Cause and Manner of Death.

Complicating this issue is the Security Hold process. As you are aware, by statute, law enforcement agencies, including the District Attorney's Office, can place a security hold on our cases which essentially prevents us from releasing information that would otherwise be released to the public. By statute, we cannot release this information without the express release by the agency that originally placed the hold. This process has garnered much media attention, especially in the Ezell Ford case, and in response, open dialogue with LAPD and the Sheriff's office was instituted to streamline the Security Hold process to ninety days, at which point information will be released, unless a positive request for extension of the security hold is made by the requesting law enforcement agency. These processes remain in the initial stages of implementation, but both LAPD and LASO are supportive of streamlining and becoming more efficient.

From an independent Medical Examiner-Coroner perspective, I was concerned with the public outcry for transparency after the Ezell Ford and Omar Abrego shootings, as well as other high profile Officer Involved Shooting cases that have occurred in the last few months. In response, in January of this year, I met with DA Jackie Lacey to explore the idea of implementing an independent review process, performed by my office, of Officer Involved Shootings and Deaths in Custody. As you can imagine, this review process can be something as simple as an internal review process, (that Sheriff Jim McDonnell likened to a Comp Stat process) to a more ambitious process with invitations to Law Enforcement/Grand Jury, to the extreme process of holding a Coroner's Inquest on the Officer Involved Shooting cases (which Clark County in Nevada and Contra Costa County in the Bay Area continue to perform regularly). In May of this year, I met with Sheriff Jim McDonnell, to discuss this particular topic (as well as others), and he was supportive of this independent review process. I have also discussed this topic with our County Counsel representative, to see which model would be best to institute.

Coming from a Sheriff-Coroner jurisdiction (Riverside County) I was fairly familiar and comfortable with the process that has become to be known as the "Coroner Review" process. Similar processes, which I have also participated in, are also in place in Orange County and San Bernardino counties, in which a formal review occurs in the presence of invited/involved law enforcement agencies, representatives from the District Attorney's Office and representatives from the standing Grand Jury. Although these Coroner Reviews are held to primarily proffer transparency and avoid conflicts of interest given the Sheriff-Coroner model, I believe they are extremely useful in a multitude of other ways as well.

After much deliberation, I thought it best to start off small, and expand in the future, if warranted. To this end, a formal Law Enforcement Involved/Death in Custody review team has been in the planning stages for the last nine months and will commence with the intake of cases starting July 1st of this year. It will be (initially) a strictly internal review process that will support our Risk Management efforts, and will be from a Quality Assurance perspective, to ensure efficiency, quality and uniformity when certifying these most difficult of cases. I believe that it will improve our throughput, as well as improve our working relationships with our law enforcement partners/customers. To what level of participation law enforcement, the District Attorney's Office, or the Grand Jury will have in the future, remains to be seen. I welcome any input or questions you may have. As always, thank you for your support.

MF:ic

C: Elaine Palaiologos
Craig Harvey